Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 03/19/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical and lumbar myelogram

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

REVIEW OUTCOME:
Upon independent review, I find that the previous adverse determination or determinations should be:

___X__Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
847.2	***62284***		***Prosp.***	***1***	***01/11/10 – 03/16/10***				***Upheld***
723.1	***62284***		***Prosp.***	***1***	***01/11/10 – 03/16/10***				***Upheld***

INFORMATION PROVIDED FOR REVIEW:
1. Certificate of Independence of the Reviewer.
2. TDI referral forms.
3. Denial letters, 02/17/10, 01/11/10, including the criteria used in the denial (ODG).
4. Clinic notes, 01/25/88.
5. Discharge summaries 02/13/88, 01/13/89.
6. Admissions, 02/08/88 through 02/13/88 and 01/03/89 through 01/13/89.
7. Radiology reports, 02/09/88.
8. Lumbar myelogram, 02/09/88 and 01/09/89.
9. Lumbar MRI scan, 02/09/88 and 12/16/88.
10. Operative report, 02/10/88 and 11/29/09.
11. Clinical notes, sixteen entries between 03/10/88 and 02/22/10.
12. Neurosurgeon's correspondence 04/27/09 – 02/22/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The patient is a male with a past history of lumbar spine surgery including a laminectomy/discectomy at L5/S1 in 1988 followed by an L5/S1 fusion in 1991. Apparently he fell on xx/xx/xx, suffering lumbar and cervical spine injury. He has had a number of MRI studies. The MRI scan of the cervical spine on 10/10/08 showed mild degenerative changes. MRI scan of the lumbar spine on 10/10/08 showed the fusion of the L5/S1 vertebral bodies. Clinic notes have stated that the patient had a past history of coronary artery bypass and heart valve surgery in the recent past. He is complaining of severe neck pain and bilateral shoulder and arm pain. He further has low back pain and bilateral hip and leg pain. His arm pain is primarily on the left side, and the leg pain is primarily on the right.

He is being considered as a candidate for surgery; however, the surgery that is being considered is not declared. There is no physical finding documented clearly indicating radiculopathy. It is not clear whether the patient is being considered as a surgical candidate for lumbar surgery, cervical surgery, or both. Lumbar and cervical myelographic studies with CT scan follow-throughs have been requested for preauthorization. The request has been denied, reconsidered and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

It would appear that the denials were appropriate. As stated above, it is not clear what specific surgeries this patient is being considered for as a candidate. He has no objective physical findings of neural compressive disease. It appears that his principle symptom is pain. There are no physical findings documented clearly indicating radiculopathy. The documentation is clearly inadequate, considering the ODG criteria.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

_____ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
_____AHCPR-Agency for Healthcare Research & Quality Guidelines.
_____DWC-Division of Workers' Compensation Policies or Guidelines.
_____European Guidelines for Management of Chronic Low Back Pain.
_____Interqual Criteria.
__X __Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X __ODG-Official Disability Guidelines & Treatment Guidelines.
_____Pressley Reed, The Medical Disability Advisor.
_____Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
_____Texas TACADA Guidelines.
_____TMF Screening Criteria Manual.
_____Peer reviewed national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)